Archdiocese of Milwaukee

Case No. 11-20059

Supplemental Plan Documents to the Chapter 11 Plan of Reorganization Dated February 12, 2014 Proposed by the Archdiocese of Milwaukee

1. Archdiocese of Milwaukee Therapy Payment Process

Archdiocese of Milwaukee Therapy Payment Process

I. Overview

This Therapy Payment Process is established pursuant to the Plan for purposes of outlining the procedures for holders of Class 9, Class 10, Class 12, and Unknown Abuse Survivor Claims to request therapy payment assistance from the Archdiocese.

Unless otherwise stated herein, capitalized terms used herein shall have the meanings assigned to them in the Plan.

Holders of Allowed Class 9, Class 10, Class 12, and Unknown Abuse Survivor Claims shall be entitled to request therapy payment assistance in accordance with the procedures outlined below. The Archdiocese may, in its sole discretion, provide therapy assistance to holders of Disallowed Class 9, Class 10, Class 12, and Unknown Abuse Survivor Claims.

The Archdiocese will normally reimburse for cognitive-behavior, prolonged exposure, and eye movement desensitization and reprocessing (EMDR) treatment approaches. The Archdiocese will not pay for missed or cancelled appointments, telephone or email consultations, normal and customary treatment reports, transportation expenses, or expenses associated with missed work or child-care.

II. Procedure for Requesting Therapy Payment Assistance

A. Prior Request Required

All requests for therapy assistance must be made in advance. The Archdiocese is not obligated to provide therapy assistance unless the request for therapy assistance has been provided to and approved of by the Archdiocese.

In cases of emergency, the Claimant's clinician or the Claimant may seek retroactive payment of therapy costs incurred; **provided, however,** that (i) the reimbursement will be provided in the Archdiocese's sole discretion; (ii) the Archdiocese will only reimburse costs incurred in the two (2) weeks preceding the date on which Archdiocese receives the reimbursement request; and (iii) the Archdiocese will only reimburse costs incurred and not otherwise paid by the Claimant's insurance.

B. Procedure for Requesting Therapy Payment Assistance

To request therapy assistance, Claimant's clinician must complete the attached "Request for Therapy Assistance" form (attached as **Exhibit A**) and return the form along with a copy of the clinician's license to:

Victim Assistance Coordinator
Archdiocese of Milwaukee
P.O. Box 079127
Milwaukee, Wisconsin 53207-0912

To ensure the quality of the therapy and objectivity in review of the proposed treatment plans, all treatment plans will be reviewed by a qualified, outside professional in the field, independent of the Archdiocese, and with the professional credentials necessary to review such plans.

The Archdiocese will respond to all requests for therapy assistance within seven (7) days.

The Archdiocese will approve the therapy request and provide for therapy assistance as outlined in Section II.C below provided the following conditions are met:

1) the Request for Therapy Assistance form is complete;

2) the patient is entitled to therapy assistance pursuant to the Plan;

3) the clinician is licensed as required in Section II.B.1 below;

4) the clinician provides a treatment plan, subject to the Archdiocese's right to request a second opinion, and an executed consent for disclosure of confidential information to the Archdiocese as required in Section II.B.2 below; and

5) the clinician submits monthly bills as required in Section II.B.4 below.

1. **Licensed Clinician**

The Archdiocese will not reimburse or pay for therapy unless the clinician is licensed as a counselor, social worker, therapist, psychologist, or psychiatrist in the state in which the clinician is practicing and will be treating the patient.

2. **Treatment Plan**

The clinician must submit a treatment plan (substantially in the form attached hereto as **Exhibit B**) and an executed consent for disclosure of confidential information (in a form, satisfactory to the Archdiocese and that complies with applicable state and federal law, including but not limited to the Health Insurance Portability and Accountability Act of 1996 and Chapter 146 of the Wisconsin Statutes) to the Archdiocese as soon as practical. In all cases, the treatment plan and the executed consent for disclosure of confidential information must be submitted to the Archdiocese prior to the clinician's fourth session with the patient. If the patient will have three (3) or fewer sessions with the clinician, the clinician is not required to submit a treatment plan.

The consent for disclosure of confidential information is required to allow the clinician to provide the treatment plan and copies of any other materials the clinician believes are necessary for the clinician justify the clinical appropriateness of the treatment and to obtain payment from the Archdiocese. The Archdiocese will not request access to any other personal health information.

The clinician must submit a follow-up treatment plan (substantially in the form attached hereto as **Exhibit B**) after the completion of the twenty-sixth (26^{th}) session, but prior to the

thirtieth (30th) session. The Archdiocese is not required to pay for treatment sessions beyond the twenty-sixth (26th) session if the clinician does not submit a follow-up treatment plan.

3. **Second Opinion of Treatment Plan**

The Archdiocese intends to provide therapy assistance to the holders of Allowed Class 9, Class 10, Class 12, and Unknown Abuse Survivor Claims for as long as is medically necessary. To ensure that resources remain available for those desiring therapy, the Archdiocese reserves the right to request a second opinion of the treatment plan submitted by the clinician.

In such circumstances, the Archdiocese may request that the clinician consult with a counter-part independent licensed clinician and obtain a second opinion from a counter-part independent licensed clinician regarding the treating clinician's proposed treatment of the patient. If such a request is made, the Archdiocese is not obligated to continue payments until the treating clinician submits an updated treatment plan containing (i) the results of the consultation with the independent clinician and (ii) a certification from the independent clinician that the independent clinician agrees with the proposed treatment. If the independent clinician disagrees with the proposed treatment, and the clinicians cannot agree on an acceptable treatment, the Archdiocese may decline payment for the additional sessions.

For purposes of this section a counter-part independent licensed clinician is a clinician who: (i) is licensed in the state in which the patient is being treated; (ii) poses the same type of license as the treating clinician (e.g., counselor, social worker, therapist, psychologist, or psychiatrist) and; (iii) is not related to or employed by the treating clinician, employed by the same entity as the treating clinician, or employed by the Archdiocese.

In the event the Archdiocese declines payments for additional sessions pursuant to this section, the patient may ask for a for review by a second independent clinician. The opinion of the second independent clinician will be binding.

Nothing in this section prevents a patient from requesting therapy assistance at a later date or from a different clinician, provided the requirements of Section II are met.

4. **Procedure for Billing**

The clinician must submit a monthly bill, including (i) the clinician's state license number; (ii) the clinician's tax identification number (or social security number); and (iii) the patient's name and address to:

Victim Assistance Coordinator
Archdiocese of Milwaukee
P.O. Box 079127
Milwaukee, Wisconsin 53207-0912

C. Change in Law or Circumstance

The Archdiocese reserves the right to revise, amend, or supplement these procedures from time to time as necessary to account for changed facts or circumstances or to comply with changes in applicable law.

III. Therapy Assistance to be Provided

If the requirements in Section II.B are met, the Archdiocese will pay for one (1), one (1) hour session per week, with a clinical therapy hour being considered to be sixty minutes. More frequent sessions may be pre-approved on a case-by-case basis. The Archdiocese will pay normal and customary fees for sessions with the clinician.

Payment for psychotropic medications, evaluation, and care may be approved on a case-by-case basis.

Payment for inpatient psychological treatment or AODA treatment may be approved on a case-by-case basis provided that the patient's clinician has made a referral for this level of care.

Exhibit A

REQUEST FOR THERAPY ASSISTANCE

REQUEST FOR THERAPY ASSISTANCE

Date _____

Patient Information

Name of Patient: _____

Address _____
_____

Clinician Information

General Information

Name of Clinician _____

Address _____
_____

Phone Number _____

Tax Identification Number
OR
Social Security Number _____

Email _____

License Information

State of Licensure _____

License Number _____

Expiration Date _____

Type of License ___ Clinical Psychologist ___Licensed Clinical Social Worker
___ Other, please specify: _____

Have you ever had disciplinary action taken against your license: ___ Yes ___ No
If yes, please explain on additional paper.

Degree/Education Information

Type of Degree ___ M.S.W. ___ Ph.D.
___ Psy.D
___ Other, please specify: _____

Where did you receive your degree from: _____

Explain your psychological orientation(s): _____
_____
_____
_____
_____

Practice Information

Practice Type
___ Solo Practice (Name of Business: _____)
___ Group Practice (Group Name: _____)
___ Facility Based Practice (Facility Name: _____)

Practice Location (if different than address above)
_____
_____

Fees
What is your fee per session: $_____
Do you offer a sliding scale: ____ Yes ____No

Which of the following age groups do you treat?
___ Children (0-12)
___ Adolescents (13-17)
___ Adults (18-39)
___Adults (over 40)

Which of the following treatment modalities do you use in your practice?
___ Individual
___ Group/Classes
___ Family
___ Marital
___ Other

What are the major problems/disorders you primarily deal with in psychotherapy:
_____
_____
_____
_____

Please summarize your clinical expertise in dealing with people who have been sexually abused:
_____
_____
_____
_____

Please list courses/workshops you have recently taken on the topic of sexual abuse:
_____
_____
_____
_____

Insurance Information

Name of Malpractice Insurance Carrier _____

_____

Address _____

Policy Number _____

Expiration Date _____

Amount of Coverage Per Occurrence _____

Professional References

	Name	Address	Telephone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Required Documentation

Please include copies of the following documents with the completed Request for Therapy Assistance

1. A copy of your license
2. A copy of your business card
3. A copy of your malpractice insurance certificate or evidence of insurance

YOU MUST INCLUDE A COPY OF AN EXECUTED CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION WHEN YOU SUBMIT THE TREATMENT PLAN TO THE ARCHDIOCESE

For internal use only

Date of Receipt _____ Patient Bankruptcy Claim Number _____

Date of Approval _____ Patient Bankruptcy Classification (circle one) 9, 10, 12 Unknown Abuse Survivor

Exhibit B

TREATMENT PLAN

ARCHDIOCESE OF MILWAUKEE
SEXUAL ABUSE PREVENTION AND RESPONSE SERVICES
COUSIN'S CENTER
3501 SOUTH LAKE DRIVE
MILWAUKEE, WISCONSIN 53207
Treatment Plan

Client Name/ID: _____

[ ] Initial
[ ] Follow-Up

Clinician's Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____
Email: _____
State of Licensure: _____
License Number: _____

Presenting Difficulties:

_____
_____
_____
_____
_____

Please describe the purpose of your sessions with the client (attach additional pages if necessary): _____

_____
_____
_____
_____

Please describe your psychotherapeutic approach or methods (attach additional pages if necessary): _____

_____
_____
_____
_____

Have you discussed your approach or methods with other professionals or considered alternative approaches or methods:

_____
_____
_____
_____
_____

Current Psychiatric Medications: **____Yes** **____No**
If yes, please identify:

_____
_____
_____
_____
_____

Have you had contact with the prescribing physician? **____Yes** **____No**

Treatment Goals:

_____
_____
_____
_____
_____

Is the person progressing in treatment? **____Yes** **____No**

Methods Used to Assess Progress:

_____
_____
_____
_____
_____

Proposed Treatment Modality

	Start Date	**How Often?**
[ ] Medication Management	_____	_____
[ ] Individual Therapy (30')	_____	_____
[ ] Individual Therapy (50-60')	_____	_____
[ ] Family/Couple Therapy	_____	_____
[ ] Group Therapy	_____	_____

Initial Date of Treatment _____ **Estimated End of Treatment:** _____

YOU MUST INCLUDE A COPY OF AN EXECUTED CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION WITH THE TREATMENT PLAN

For internal use only
[ ] Approved as submitted
[ ] Second opinion of treatment plan required

_____
_____
_____
_____